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Partnerships for Health Reform

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For Policymakers

References for International Development

Health Policies, Incentives, Financing, Organization, and Management

Decision Making for Equity in Health Sector Reform

Health sector reforms that many countries around the world are undertaking have goals of improving equity, access, quality, efficiency, and/or financial sustainability of their health systems. Equity has long been a cornerstone of government policy in the health sector, and it underlies the traditional approaches under which ministries of health or social security provide services free of charge at the time of use.

A perception exists in many countries that the newer reform emphases on decentralization, efficiency, cost-effective allocation of public sector health resources, and financing alternatives for the public sector services conflict with or compromise the more traditional equity goals. These and other health reforms – changing roles for the ministry of health, definition of essential service packages – have made understanding equity and assessing reform's likely effects on equity more complex. Little field-based evidence or guidance exists on how equity can be achieved while simultaneously trying to make the overall public and private health system more efficient, cost-effective, and sustainable.

This primer proposes a framework for policymakers in developing and transitional countries to use when they consider equity issues in the context of health reform initiatives and goals. It summarizes key service delivery and financing decisions in design and implementation of programs to address equity, while paying attention to cost-effective approaches and the need to adapt equity policies to specific country circumstances. The primer also identifies indicators that might be used to monitor progress in equity, and it highlights lessons learned from real-world experience in developing operational equity strategies.

Purpose of the Primer

The purpose of the primer is to provide policymakers with a road map for navigating the issues described above, rather than to discuss any particular component in depth or to propose individual solutions. As a road map, the primer suggests a framework, questions, steps, and options that policymakers and policy implementers might use to ensure that reform policies are "equitable" or have an "equitable impact." While the primer includes illustrative monitoring indicators, it does not provide detailed guidance for evaluating the equity impact of all of the individual reforms occurring in a country, such as setting up or refining

Defining as well as achieving equity goals involves balancing the interests of various population, income, commercial, and health provider groups. It is a preeminently political process requiring leadership, negotiation skills, and systems for reaching compromise.



a social or private insurance fund, or changing the ways in which hospitals are paid, or fine-tuning decentralization of public sector health services. Given the multiple current approaches to reform, complexities of country situations, and lack of clarity around the world on the topic of "equity," the road map approach is designed as a first step in filling a gap and is intended to contribute to development of more specific and effective equity policies that suit circumstances in each country.

In general, this primer is concerned with "equitable policies" in the context of health reform, that is, with policies that might yield greater equity in access to health services. Although it discusses country conditions and reform policies as they affect a number of typical target groups (e.g., high-risk individuals, children, women), it focuses on the poor, because, as the most numerous disadvantaged group, the poor are central in many countries' concern for equity. Thus, policy discussions in many countries use the term "equity," or "equity policy," to connote policies and practices intended primarily to ensure that poorer families are not left out of the health system because they cannot afford, or do not have access to, health care. In addition, equity for the poor has raised some of the most heated controversy and presents one of the biggest challenges in relation to other health reforms that aim to increase efficiency and financial sustainability for public sector health services.

Perspectives on Equity

Equity in the health sector has many different faces. Some policymakers worry most about rural households having less equal access to basic health care and to hospital care than urban households have. Many health care providers are concerned about differences in health status of children or of the elderly or the high mortality rates that women face from childbirth. Advocates for the poor are most often concerned that the poorest, whether they live in the city or countryside, have less access to health care, cannot afford the services that are available, use fewer services, and are likely to be sicker from basic health problems that are preventable than are better-off population groups. They also raise issues about factors outside the health sector that affect health of the poor, such as income, education, nutrition, water, and sanitation.

Economists often emphasize the equity aspects of alternative ways to generate funds for health care, pointing out differences between various tax-based methods, social security, private insurance, other risk pooling schemes, and out-of-pocket payments. Ministry of finance staff and international lenders concerned with efficiency and cost-effectiveness in ministry of health spending often emphasize the need for cost-effective ways to serve the poor and other target groups rather than providing "free care" to all regardless of ability to pay.

Insurance company executives, confronted with inequalities in health status, strive to enroll younger and healthier patients in group plans and managed care schemes, require waiting periods for enrollees, and construct complex systems of premiums, deductibles, and co-payments in order to reduce their risks and costs. On the other hand, policymakers in ministries of health may worry that such requirements of private insurance systems create further inequities of financing and access between covered and uncovered households, which are usually poorer and not engaged in formal sector wage employment. They may be concerned that such features create even more complex equity problems for public sectors that are the last resort for uncovered, poorer, and sicker members of the population.

Other perspectives on equity in the health sector stem from perceived differences between health care delivered by public and private health providers. Ministry of health officials are often concerned about the existence of two classes of care, with poorer patients using the public health facilities where services are free of charge and patients who can afford to pay for care using private providers. They know that higher revenues enable the private providers to have better amenities while strained public budgets leave ministry facilities overcrowded with long waiting times, understocked with medicines, underequipped, and needing repair.

Ministries may also be concerned that when these aspects of quality are low in public facilities even the poorest bypass low quality "free care" to seek – and pay for – health care from private providers. The poor also spend large amounts on medications from private pharmacies. One result of this phenomenon, especially in poorer countries, is that poor people often spend much higher shares of their household budget on health care (e.g., 10–15 percent) than do better-off people (e.g., 3–5 percent). Poor quality in public sector health facilities thus affects equity for the poor not only because public patients are generally low-income people. It also forces poorer families to choose between

Table 1: **Common Equity Problems for Different Population Groups**

Typical Target Groups	Common Equity Problems		
	Access	Utilization	Financing
Income: poorest ***Health status:*** sickest ***Age:*** children, elderly ***Gender:*** women ***Residence:*** rural ***Overlapping groups:*** -poor women and children -rural elderly -poor with chronic disease (e.g., TB)	Do not have access to health care that meets their needs Services less available to them than to counterparts in other groups	Use services less than needed Use services less than their counterparts in other groups	Money and time costs for user fees, insurance premia, transport, waiting for care, and medicines pose barriers to use of needed health care Costs of health care absorb higher proportion of income than for counterparts in other groups

spending large proportions of their income on health services or foregoing health care and medications altogether.

Some analysts focus primarily on broad equity indicators at the country level and concentrate on statistical measures (e.g., concentration curves, Gini coefficients) that evaluate the equity of socioeconomic differences in health status, and who pays for and who benefits from health care. These macro-level analyses can be useful in health sector reform efforts as a way to assess the current situation and identify whether new financing or program options need to be undertaken to improve equity of access and/or financing. They can also be used to make comparisons across countries and to monitor the impact of financing and program reforms on overall distributional equity.

Other analysts focus on subsets of these issues, with emphasis on means testing and other targeting methods to protect the poor or other disadvantaged groups. These more micro-level studies often evaluate the effectiveness of alternative targeting mechanisms in mitigating financial barriers to health service utilization.

There is no common yardstick to measure or evaluate these dimensions of equity. Issues related to variations in health status, disease conditions, utilization of health services, income, and who is paying for and benefiting from public and private health care services are all important aspects of the "equity problem" that policymakers face. And they are more or less prominent depending on the structure of the country's health system.

These examples also serve to illustrate that there are competing pressures even within equity goals. Defining goals for equity and establishing a workable consensus on what constitutes an equitable policy depends on a society's values and norms. Both defining and achieving equity goals involves balancing the interests of different geographic, demographic, income, commercial, and health provider groups. Because of this, defining and achieving equity goals is a preeminently political process requiring leadership and negotiation skills and systems for reaching compromise on differences in opinion and interest.

Equity Problems and Policies for Access, Utilization, and Financing

Table 1 summarizes obstacles to equity of access, utilization, and financing that are faced by population groups commonly considered to be unequal or disadvantaged with respect to health status and the health service system. To remedy these inequities, some countries offer policies that strive for equal geographic access (e.g., care within 5 kilometers of home) for everyone, equal utilization across income groups, or equal quality treatment for all patients. Other countries aim to spend relatively more health dollars on the poor, or more on high-risk or "vulnerable groups," or more on cost-effective health services that benefit the public good. Still others seek "health for all" as the primary equity goal.

Specific equity goals, however, are rarely explicit in official documents and available to health providers and the population. Often a single general statement in a law, ministry decree, or public pronouncement serves as a country's "policy" about equity in the health sector. Typical examples include "All people have a right to health care," "All families must have access to quality, affordable health," and "Services in the public sector will be provided free to the poor." One of the most common broad strategies is to provide health services in the public sector free of charge at the time of use regardless of income, health status, or other criteria.

Some countries have been slightly more specific, with regulations or ministry operational

Table 2: **Vertical and Horizontal Dimensions of Equity in Health Financing and Service Delivery**

Equity in Service Delivery	Equity in Financing	
	High	**Low**
High	Same health need, same treatment (horizontal equity) Different income, different payment according to ability to pay (vertical equity) ***NO EQUITY PROBLEM***	Same health need, different treatment (horizontal inequity) Different income, different payment according to ability to pay (vertical equity)
Low	Same health need, same treatment (horizontal equity) Different income, same payment without regard to ability to pay (vertical inequity)	Same health need, different treatment (horizontal inequity) Different income, same payment without regard to ability to pay (vertical inequity) ***BOTH EQUITY PROBLEMS***

guides that list criteria for identifying "equitable access," "equal quality," or "the poor." In most cases, however, a country's equity policy for health is implicit in a range of policies and regulations that affect access, quality, utilization, and financing of health services.

Indeed, one point this primer seeks to illustrate is that most policies and practices in the health sector have an effect on, or implications for, equity. Simply providing health services in the public sector free of charge at the time of use will not ensure equitable access to quality care for the poor or other disadvantaged target groups. It is important, as subsequent sections of this primer show, to assess the equity impact of the whole array of policies and practices in a country's health sector to examine whether they are internally consistent and whether they produce conflicting or reinforcing incentives for providers, consumers, and other stakeholders.

Benchmarks for Defining Equity

To sort out the various perspectives and practices related to equity, it is useful to think of equity along horizontal (how are people the same) and vertical (how are people different) dimensions. Policymakers most concerned with equity of access and utilization tend to focus on the horizontal dimension of achieving "equal access according to need," that is, people with the same health needs "should" have the same access and receive the same treatment. The assumption is that if this dimension of equity were achieved, the health sector would be playing its part in reducing inequalities in health status. Those concerned with equity in financing tend to focus on the vertical dimension, "services financed according to ability to pay," that is, people with different ability to pay "should" make correspondingly different payments.

Many policymakers and analysts who have used this approach have reached consensus that a good starting point for a definition of "equity" in the health sector is "equal access to health services according to need, financed according to ability to pay." This starting point can be taken as a core definition for minimal criteria that an equitable policy would meet. Table 2 illustrates how this definition can be applied to assess whether an equity problem exists in service delivery and/or financing.

With respect to the (horizontal) access dimension, a more expansive definition might go beyond simple availability of health services to include reference to equal utilization of health services according to need. Under this broader definition, a policy to improve equity might seek, for example, to develop interventions that close the gap between richer and poorer households (or other target groups) in utilization of health services. The emphasis on a utilization gap might be associated with active outreach interventions to improve the health status of the target group in contrast to a more passive policy of assuring that the services are merely available. Other more expansive definitions of equitable access might include the notion of "equal access to equal quality of health care" or provision of "equally effective treatment to all." Such definitions might be adopted in recognition

A good starting point for a definition of "equity" in the health sector is "equal access to health services according to need, financed according to ability to pay."

Table 3: **Benchmarks for Defining Equity Issues in the Health Sector: Illustrative Policy Issues for the Poor**

	Same Health Needs (Horizontal equity issue: All poor people with same health need, compared with each other)	**Different Health Needs** (Vertical equity issue: All poor people with individual health needs compared with people with other health needs)
	(1)	(2)
Same Ability to Pay (Horizontal equity issue: All poor people, compared with each other)	Does full coverage exist for the poor for target needs, e.g., immunization, emergency obstetric care, HIV/AIDS prevention and treatment? Do all the poor make similar payments for similar health care needs? Do all the poor benefit from the mechanisms that exist to protect them against the costs of health care?	Are all the individual health needs of all the poor being addressed, e.g., for the poor with different combinations of infectious, chronic, and acute health problems? Do all the poor make similar payments for similar health care needs? Do all the poor benefit from the mechanisms that exist to protect them against the costs of health care?
	(3)	(4)
Different Ability to Pay (Vertical equity issue: Poor people compared with better-off people)	Do the poor use health services to the same extent as other income groups for health problems they have in common, e.g., immunization, family planning, maternal care, TB, HIV/AIDS? Do the poor pay higher proportions of their income for health care needs than do other income groups?	Are the special health problems of the poor addressed to the same extent as health problems of other income groups, e.g., higher prevalence of infectious diseases among the poor due to inadequate sanitary and/or water quality and supply conditions? Do the poor pay higher proportions of their income for health care needs than do other income groups?

of a need to redress imbalances in quality of care in order to improve effectiveness and hence health status.

With respect to the (vertical) financing dimension of equity, the basic definition makes no distinction between (1) payments made at the time of using health services (e.g., through fees or co-payments for services and medicines) and (2) payments made in advance (e.g., through taxes that finance public sector health services, insurance premia, or other prepaid arrangements). Frequently, the principle of equity in financing is applied to ability to pay at the time of use. The "free care" policies for services provided by the public sector that many countries in Latin America, Africa, Asia and the Near East, and Europe have adopted are common examples of policies that reflect this notion. Providing care free of charge at the time of use is also administratively the simplest way to accommodate differences in ability to pay and to ensure that fees are not an obstacle to using needed health services. More complex ways to consider ability to pay at the time of use might include sliding fee scales, fee waivers or exemptions, or vouchers.

Even more complex and expansive definitions of equity in financing are associated with policies that take into account all the payments that people make for health care, including service fees and co-payments (or lack thereof), premia for private or employer-based insurance, prepayment scheme contributions, social insurance taxes, and the general taxes that finance health services in the public sector. Under this broader financing concept, a country could try to ensure equity according to ability to pay through a policy of "free care at the time of use" combined with financing through a progressive tax structure that requires higher tax rates at higher income levels. In these cases, defining what is needed to make the health financing policy of a country more equitable extends to analysis of how progressive the tax structure is, how equitably employment and health insurance benefits are distributed, what proportion of total household income is spent on health by various socioeconomic groups, and/or other more elaborate ways to assess whether people are paying for preventive and curative health care services in proportion to their ability to pay.

Table 3 illustrates how these vertical and horizontal dimensions of equity in the finance and delivery of health care might be applied to defining equity issues for the poor. Cell 3 (combining access to services for people with the same

health needs but different ability to pay) illustrates the most common emphasis across countries. Policymakers have given the least attention to cell 2, which addresses different health needs among the poor (people with the same ability to pay). Cells 1 and 4 illustrate issues that can be more prominent in some countries than in others. In cell 1, the focus is on equity among the poor, that is, do most of the poor have similar access to, and pay similar amounts for, health care? Cell 4 focuses on inequities that may exist in both access and financing between the poor and other income groups.

It is generally recognized that no health system will achieve perfect equity, however defined. As noted above, policy statements that set out broad equity goals are a first step, but the next steps – implementation and achieving results – require more specific decisions and operating guidelines that take into account the health system as a whole as well as the broader country context. Specifics about equity also involve making links with other health sector reform goals for improving access, quality, efficiency, and sustainability.

Framework for Linking Health Sector Reform and Equity Policies

Whatever a country's definition or goals for equity, designing, implementing, and assessing equity in its health sector requires an understanding of the characteristics of the health care system as a whole and linkages among the system's various components. For example, equity assessments need to go beyond analysis of user fees for public sector health care to look at a whole variety of health system features, such as coordination among public and private health care providers, resource distribution, decentralization, contracting and insurance arrangements, and incentive mechanisms for health personnel to provide high quality care to target groups and to people to use those services.

Addressing equity in health also demands knowledge of factors outside the health care system, such as income, nutrition, water supply and sanitation, education, lifestyle, and the political system. Similarly, decisions taken not primarily for health equity reasons but, for example, to enhance economic growth through wider education of women or a more extensive road or potable water system also have an impact on improving (or not) the health status of the poor and other disadvantaged groups. Thus, many decisions affecting the socioeconomic status of the population and virtually all health reform decisions and initiatives that countries undertake have an implicit equity component, and a country's equity policy needs to be integrally linked with other reform initiatives.

Figure 1 illustrates these interconnections and puts equity in the broader context. It shows how, in a given country, a flow of decisions, changed incentives and utilization, monitoring, evaluation, and feedback can lead to more equitable results – in this example, "more equitable utilization by the target group."

Conditions at the left of the figure – the health status, socioeconomic situation, and political system of a country – provide the basic parameters for a country's health service delivery and financing systems. These service delivery and financing systems, in turn, present the conditions that health sector policymakers act on directly. Evaluating these broader societal and health sector conditions from an equity (or efficiency or quality or sustainability) perspective often leads a country to undertake reforms in health service delivery and financing strategy (shown in the middle of Figure 1).

The middle section of the figure gives examples of key policy, implementation, and health delivery decisions needed to develop a reform strategy to improve equity. The interaction of the delivery and financing strategies (shown by the vertical arrows in the center) leads to the results on the right. An intermediate result, "improved incentives for providers and the target group," then produces the final result of "more equitable utilization by the target group." Ultimately, it is expected that the more equitable utilization will improve the health status of the target group.

The figure oversimplifies many of the circular and iterative processes that actually take place in developing and refining an equity policy as part of a country's health sector reform agenda. Nevertheless, it maps out the main elements of the process and the decisions that must be made to produce the results that the policy seeks to achieve. Following is a description of how the process works.

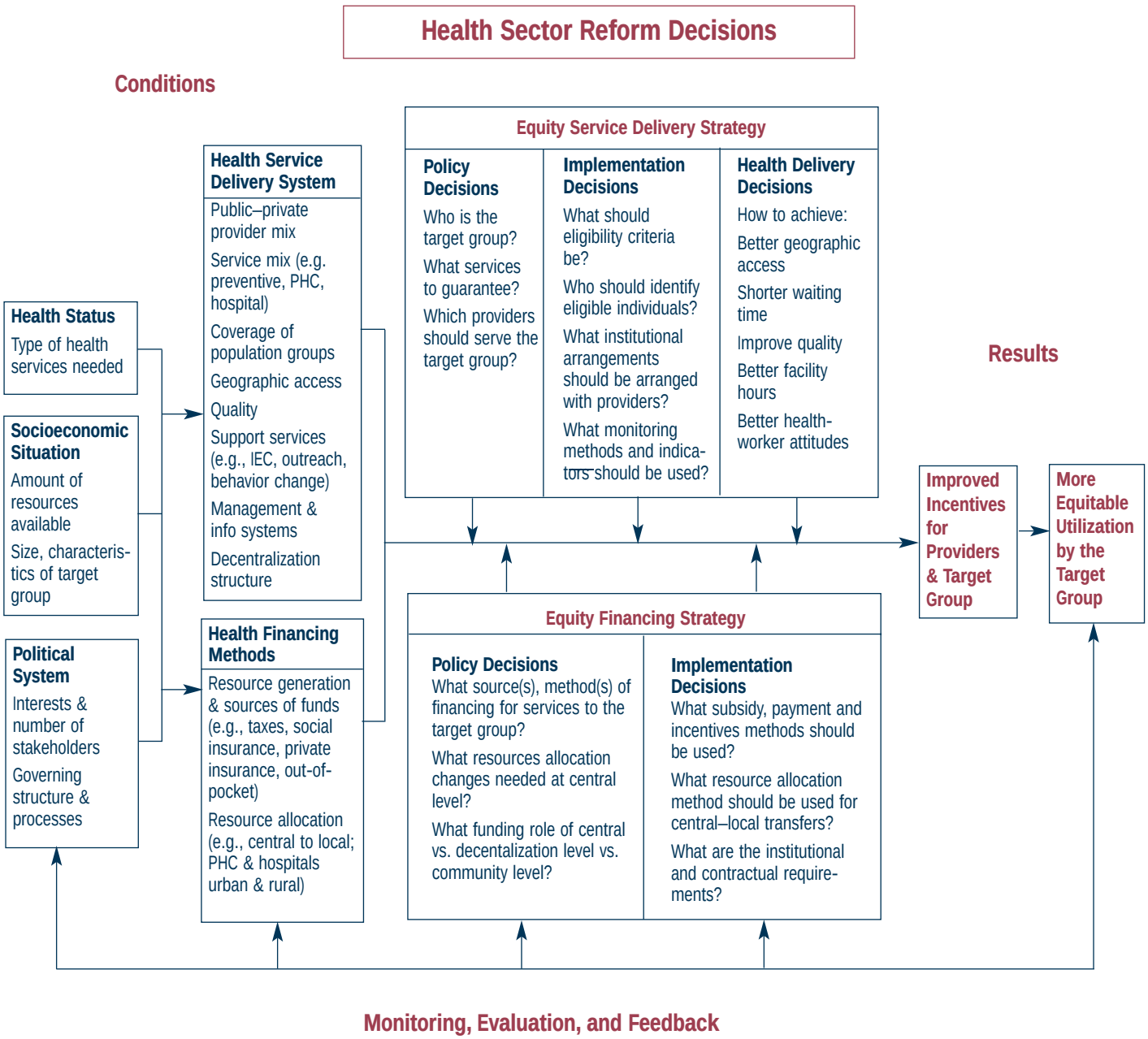
Steps in the Equity Decision Process

Evaluate evidence based on country conditions

No single equity policy works for all countries. Each country has a particular configuration of health status, and health, socioeconomic, and political conditions that determine what kind of equity improvements are needed and what kind of equity policies and implementation strategies will be acceptable and sustainable.

For example, the configuration and distribution of health status among various population groups determines the nature of health services needed by the population at large, as well as by the target population group. The country's socioeconomic situation dictates the level of resources

Figure 1: **Health Sector Reform & Equity Policies**



Note: PHC = primary health care, IEC = information, education, and communication

available to deal with equity issues. When the poor are the equity target population, socioeconomic conditions also directly determine the size and characteristics of the target group. Also affecting equity policy is the political system, its governing structure and decision processes, roles and responsibilities of the ministry of health, and the number and nature of stakeholders and interest groups involved or accommodated by the equity policy. The political and governing system also affects how complex the consensus-building process will be.

In addition to the general country conditions illustrated in Figure 1, several aspects of the health service delivery system and methods of financing and resource allocation affect what kinds of equity reforms are needed and what kinds of reforms would be effective. Some key aspects of the service delivery system include the public–private provider mix, coverage of population groups, quality, and decentralization structure. Important aspects of financing include the main sources of funds for health care (e.g., taxes, social security

Box 1. Variations in Patterns of Equity and Inequity across Eight Developing and Transitional Countries

Findings from a recent analysis of developing and transitional countries illustrate the importance of collecting empirical data about specific equity questions in each country's health sector, rather than relying on conventional wisdom. The Partnerships for Heath Reform project analyzed data from eight countries – Burkina Faso, Guatemala, Kazakhstan, Kyrgyzstan, Paraguay, South Africa, Thailand, and Zambia – to examine differences among income groups in various health care utilization and spending patterns.

The data show that in most, but not all countries, there was a clear pattern that

- wealthier households are more likely to be seen by a doctor than are poorer groups, and
- richer groups are more likely to receive medicines when they are ill in all countries studied except Paraguay.

In contrast, there was

- no consistent pattern of difference across income groups in each of the countries in percentage of those seeking care when ill or percentage of those seeking care that go to a hospital. In some countries rich and poor households have similar patterns of care seeking on these measures; in other countries poor households may seek care less and see doctors less often than better-off ones.

In addition, the data showed

- no clear pattern that richer households are more likely to use the private sector. Only in Guatemala and South Africa were wealthier households clearly more likely to use privately provided health care.

With respect to measures of equity in financing, the data show, as expected, that

- richer population groups spend more on health care, measured in absolute terms, than do poorer groups.

But there was

- no clear pattern among the countries studied concerning the percentage of total reported household consumption spent on health care. In Burkina Faso, Paraguay, and Thailand, wealthier households spend a smaller share of their total consumption on health care than do poorer households. In Guatemala and South Africa, however, richer groups tend to spend a higher percentage of their consumption on health care than do poorer groups.

Special circumstances in Guatemala and South Africa explain these departures from the usual pattern. In South Africa, for example, the highly skewed income distribution concentrates the minority white population in the highest income group. This population buys privately provided care or insurance coverage for private care that is beyond the means of the other 80 percent of the population and so spends about 31 percent of its consumption on health care. In contrast, the majority of the population spends about 10–12 percent of their consumption on health care.

Data from these countries also provides evidence that averages for each income group also need to be examined in more depth. For example, it is especially important to know the age and sex distribution of the income groups, as well as to examine age and gender separately, regardless of income.

Sources: Makinen, M. et al. 1999. *Synthesis of Findings from Studies of Equity of Health Sector Revenue Generation and Allocation in Eight Countries.* Major Applied Research 3, Technical Paper 1. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc. Makinen, M. et al. 2000. *Bulletin of the World Health Organization* 78:55-65.

Box 2. Links between Health Reforms and Changing Equity Situations in Vietnam

In 1986, Vietnam began to shift to a market economy and removed many government subsidies for social services and health care. The government also lifted legal restrictions on private health care practice and allowed public health clinics, along with private clinics and pharmacies, to charge fees. The goal of these reforms was to encourage higher-income individuals to use private providers and thus free state-subsidized services for serving the poor. The government also hoped that privatization would encourage staff to leave the state sector, thus decreasing the government's salary budget.

These policies have, however, diminished equity in several ways. A serious shortage of medical personnel occurred in rural areas, making health care less accessible geographically. A general devolution of authority and resources to the local level exacerbated the inequality. Finally, rather than complementing the national health system, the private sector is draining state resources, since doctors are allowed to use state facilities after government hours, for private practice.

Source: Ladinsky, J.L., Nguyen, H.T., and Volk, N.D. "Changes in the Health Care System of Vietnam in Response to the Emerging Market Economy." *Journal of Public Policy* 21 (1):82-98.

funds, local revenues) and allocation of funds for different types and levels of services.

Box 1 describes a range of equity conditions in eight countries in Africa, Central Asia, Latin America, and Southeast Asia that illustrate the need to examine each country's evidence about what kinds of equity reforms are needed.

Understand the links between equity and broader reforms in health service delivery and financing

Developing empirical evidence about the performance of a country's service delivery and financing structure is key to making effective links between equity reforms and broader health reforms. The health service delivery conditions that create a need for health reform are usually also those that create a need for equity improvements. Similarly, conditions that generate or result in inequities are also frequently associated with system inefficiencies, poor quality, inadequate overall access, and unsustainable financing situations. This interaction exists throughout the health reform process. Any appreciable change(s) in

service delivery or financing affect equity and equity decisions need to be compatible with the reformed organization, management, and financing of service delivery.

For example, in countries where consumers have a choice of provider – public (ministry of health), private, and perhaps social security provider – reforms that improve the quality (e.g., drug availability) or efficiency (e.g., lower waiting time, more patients seen per day) of a provider attract more clients to that provider. Some new users switch from another source of care; others are first time users who did not previously seek care in the formal health sector. These changes in patterns of utilization then further enhance the efficiency and sustainability of the higher quality provider and harm the prospects for other providers who may have lost patients.

Depending on the new configuration of utilization, equity for the poor may have increased – for example, if the poor now have access to high quality care at public clinics or hospitals instead of paying more costly private providers for that level of quality. In contrast, the new configuration may diminish equity for the poor – for example, if the quality increase occurs at a private or social security provider with prohibitively high prices and there is no equally accessible, quality public provider. Similarly, equity of financing may have increased or decreased. For example, if better-off people switch from private providers where they can afford to pay for health services to free care at a public, tax-supported health care provider and they have not paid proportionately higher taxes, then overall financial equity may have decreased.

Box 2 describes changes in Vietnam that illustrate another kind of link between reforms and equity in access to health care.

Develop more equitable service delivery and financing strategies

It is useful to group equity policy reform decisions into two sets: those related to health service delivery strategy for eligibles in the target group and those related to the financing strategy for those services. As the arrows in Figure 1 show, these sets of decisions interact with each other to create the incentives (or disincentives) for an equitable policy result. As indicated above, empirical data about the health service delivery system and financing methods determine the specific areas in which decisions and changed policies are needed. Box 3 illustrates how reforms in service delivery and financing interacted to create greater equity in Rwanda.

In general, key decisions about service delivery reform determine the size and composition of the target group, services the target group will receive to improve equity, and details about

Box 3. Developing More Equitable Service Delivery and Financing in Rwanda

Why changes were needed. In 1996, Rwanda reintroduced user fees in health centers and hospitals. By 1998, utilization of primary health care services had fallen to 0.28 consultations per person per year. In response to this situation, the Ministry of Health sought to make major reforms to improve equity in access to quality care for rural populations by offering a basic package of services that includes preventive and basic curative care, as well as essential drugs; strengthen financing of health centers to mobilize additional resources; and increase community participation in health care delivery and financing.

How the plan works. Working with the Ministry of Health, the Partnerships for Health Reform project helped develop and implement pilot prepayment systems in three districts. The Ministry sponsored numerous community meetings to obtain local input and established a participatory structure with general assemblies of members and elected "executive bureaus," each partnering with a health center. These bureaus in turn elect a total of five representatives to serve on a district-level federation of schemes.

The Ministry also conducted training for providers and bureau members on administration, accounting tools, IEC, and management. In addition, actions were undertaken to assure availability of drugs and supplies.

Under the prepayment system, households pay an annual premium of about US$7.50 that entitles them – after a one month waiting period – to the defined package of benefits at a health center of their choice. Members make a small co-payment of about US$0.30 per episode of care at the health center. Providers are reimbursed on a capitation basis for each member enrolled in their health center. With this capitation amount, the health workers must provide all services in the basic package.

Results for equity. In general, the pressure of better-informed members with increased negotiating power due to capitation has engendered better quality of services, which in turn has translated into more members and use of health services more in line with needs. Benefits already evident include the following:

- To recruit more members, health centers have taken steps to build a reputation for offering good care. In the first 12 months, almost 100,000 Rwandans registered with the scheme, and registration continues at an overall steady pace.
- Members are making 1.3–1.8 primary care visits per year, compared to less than 0.28 visits per year for non-members.
- Almost twice as many members as non-members delivered their babies at a health facility rather than at home with an untrained attendant.
- Members have shifted from self-medication at home to seeking care and medicines at the health facility and members spend from half to one-third less per episode to remedy their illnesses than do non-members.
- In districts where enrollment is high overall, the poorest households have enrolled in the system at almost the same rate as the next two highest income quartiles.
- The church offered to use the prepayment system as a vehicle to subsidize membership for poor widows in one district, while some poor households have formed small groups to pool funds for each other's membership fees.
- The participatory structure has promoted accountability. During general assemblies with scheme members, health centers are increasingly asked by the population to explain treatment-related issues.

Next steps. More time is needed to establish and train district-level units for monitoring and evaluating quality indicators. The prepayment systems also need to develop reliable mechanisms to ensure that the very poorest households in the lowest income quartile receive subsidies for the annual membership fee.

Sources: Schneider, P., Diop, F., and Bucyana, S. 2000. *Development and Implementation of Prepayment Schemes in Rwanda.* Technical Report No. 45. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc. Schneider, P., Diop F., Leighton, C. 2001. *Pilot Testing Prepayment for Heath Services in Rwanda.* Technical Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Box 4. Incentives that Target Increased Use of Maternal Services by Poor Women in Indonesia and China

Planning reforms to strengthen health systems and resolve equity problems often requires policymakers to rethink the incentives they wish to set for providers and consumers. Many discussions in this context have focused on performance-based incentives designed to improve the efficiency and quality of health services by tying provider performance directly to provider income. While much discussed, performance-based incentives for providers have not been put into practice extensively in low- and middle-income countries – and particularly not for primary care services that include priority health interventions related to maternal and child health. Nor have incentives that remove financial barriers that restrict poor women's use of maternal health services been tried frequently.

With the help of World Bank loans, both Indonesia and China have introduced pilot demonstrations to improve equity for poor women by using incentives for both providers and consumers.

The pilots in both countries provide poor women with vouchers that they can use in place of cash to obtain delivery and maternal and child health services. The providers then submit the vouchers for reimbursement. The Indonesia Safe Motherhood project includes performance-based contracts between the government and private nurse–midwives to implement these arrangements. In China, the World Bank-assisted Comprehensive Maternal and Child Health Project uses a Poverty Alleviation Fund to reimburse government providers who participate in the program.

Through these incentives, the ministries of health hope to increase both availability and utilization of delivery and maternal and child health services for poor women. The Indonesian Ministry of Health also hopes to increase women's bargaining power and ability to obtain quality services by enabling them to choose among service providers.

More in-depth evaluations of both the Indonesia and China pilots are planned to determine if these pilots have been effective in providing poor women with high quality services that they find satisfactory. Evaluations will also determine whether these are models that should be scaled up nationwide.

Source: For related information see, the World Bank website on poverty and health: www.worldbank.org/poverty/health.

implementation, such as eligibility criteria, management, and institutional arrangements. Related decisions address broader aspects of the health delivery system, such as geographic access, quality, and health worker attitudes.

Key decisions about financing determine the mix of funding sources to be used and possible changes in resource allocation methods and amounts. This also involves decisions about implementation details related to specific subsidy, payment, and incentive methods, along with institutional and contractual arrangements.

Identify incentives and results to be achieved from more equitable policies

The equity policy depicted in Figure 1 seeks "more equitable utilization by the target group" to bring their use of health services more in line with levels of the rest of the population. These health services could be a package of essential care, selected preventive care services, or a combination of primary and hospital-based care, depending on a country's priorities and the particular unmet needs of the target group in that country.

A key intermediate result in the quest for equitable utilization is usually, as Figure 1 suggests, a change in incentives to encourage providers to deliver services that meet the needs of the poor. Frequently and equally important, new incentives are needed to encourage the poor to use the services, usually by reducing obstacles such as cost and geographic access. Potential incentives include government subsidies to private providers where public services are not available, so that these providers offer needed services to poorer patients who could otherwise not afford private health care. As indicated above, a variety of decisions are needed about reforms in the country's service delivery and financing systems to produce these changed incentives.

Box 4 describes voucher programs in Indonesia and China that seek to increase women's utilization of both public and private providers of maternal and child health care.

Monitor, evaluate, and incorporate feedback

As with any reform policy, monitoring and evaluation are key to knowing whether the policy is achieving the desired results and to assuring effective implementation and ongoing relevance of the strategy. As Figure 1 shows, information from the monitoring and evaluation system can be used to update specific service delivery and financing strategies of the equity policy, as well as broader health sector reforms. Success of the equity policy is likely to also improve the health status and socioeconomic conditions of the target group, as well as realign stakeholder interests and require adjustments in political strategies to maintain consensus.

Box 5 illustrates the use of feedback from a local evaluation that has led to community action to improve equity in Mali.

Specific Design and Implementation Decisions

Table 4 expands upon the preceding discussion by listing in more detail the key decisions that ministries of health have made in designing an operational equity strategy and the program to implement that strategy. Information in the table is based on the experience of many countries. Like much of this primer, the table focuses on the poor



as the target group for whom inequities need to be corrected. Decisions include:

- ***Design decisions:*** identifying the target group, health services to be provided, financing mechanisms, providers who will deliver the services, and central and local governments' roles.
- ***Implementation decisions:*** specifying eligibility criteria for the target group, the process for determining eligibility, incentives for providers to serve the target group, and incentives for the target group to use the services.

Table 4 also identifies typical policy and program options for each decision, issues to be addressed in deciding among the options, and information and analysis needed.

Following is a brief description of the main equity decisions in Table 4.

Target Group and Services

Decisions about criteria that identify who is "poor" need to match each country's own political and cultural notion of what is fair and equitable. In the case of equity for the poor, it is important to decide whether the country will target all the poor or only a subset (e.g., lowest income quintile). This point is especially relevant in countries where a large portion or more than half of the population is considered below the poverty threshold and where government resources are scarce. In such cases, if the ministry of health adopts an equity policy covering the majority of the population, scarce resources may limit the range or quality of services provided to that group. Therefore, these ministries may choose to offer coverage for only the most cost-effective preventive services (e.g., immunization against childhood diseases) and/or for services that address important causes of mortality (e.g., emergency obstetrical care).

Financing

For an equity strategy to be effective and sustainable, it is essential that policymakers estimate the costs and consider how the services will be funded. This decision should be based on the existing configuration of funding sources and methods for health services in the country (e.g., social security, private insurance, ministry of health budget, consumer out-of-pocket payments). Criteria for

Box 5. **Local Evaluation and Feedback on Equity in Mali**

Due to a recent infrastructure development program, approximately 40 percent of Mali's population now lives within 15 kilometers of a health facility that provides a minimum package of services. Along with other measures, this expanded access has helped to boost utilization for preventive services, such as prenatal visits and vaccination for children under one year. But use of curative care and other services remains low, less than 0.3 visits per person per year, especially among the most rural, disadvantaged populations.

The Ministry of Health has encouraged communities to mobilize local solidarity mechanisms to address equity problems that remain, including problems that may derive from user fees and related financial obstacles. As a first step in designing effective protection mechanisms, such as fee waivers or a solidarity fund to improve utilization of health services among the poor, local investigators, with assistance from the Partnerships for Health Reform, sought to understand the health needs of different income groups, their health seeking behavior, and the range and quality of health services available to them. The investigators conducted household and provider surveys in two sites, one rural (Bla) and one urban (Sikasso).

Survey results demonstrated that the need to pay user fees is not always the most significant factor in the decision to seek care. When those interviewed were asked what the most important factor was in choosing to seek care at a particular provider, the two most often cited reasons were the presence of competent personnel and geographic proximity to home. Perceived competence was more important for those seeking treatment of fever (malaria) and sexually transmitted infections, while for pregnancy-related care and family planning, proximity was most important.

Community meetings were held in both sites to discuss the survey findings. The communities concluded that the findings have at least two important implications for removing obstacles that prevent the poor – and others – from seeking care for priority services:

- A package of interventions is needed to overcome obstacles to use. Action is needed to improve quality of health personnel and infrastructure (e.g., equipment and supplies) and outreach, as well as operation of financial protection mechanisms for the poor.
- Interventions to protect the poor from financial obstacles need to be targeted to specific groups for specific services. Findings showed that men and women, and urban and rural populations, tend to use or not use services differently. Income obstacles were significant reasons for non-use of some priority services but not for others.

Based on these data and discussions, local groups have planned changes on several fronts to increase utilization and to remove differences between low and higher income and urban and rural groups.

Source: Kelley A.G. et al. 2001. *Equity Initiative in Mali: Report on a Survey of Demand, Supply and Quality of Basic Health Care in the Commune of Sikasso and the Cercle of Bla, Mali.* Technical Report. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Table 4a: **Design Decisions and Options to Improve Equity in Health Service Delivery and Financing for the Poor**

Equity Decision	Policy & Program Options	Issues	Information & Analysis Needed
Target Group Which group(s) should be targeted? Who are "the poor" who need government assurance of access to health care?	• Patients, who, based on informal, local knowledge, are "unable to pay." • Population with income in lowest X percentile (e.g., 10%, 20%, 25%) • Population below "poverty threshold" • Population residing in generally "poor" areas (e.g., rural, selected neighborhoods, etc.) • Population with certain demographic, socioeconomic characteristics (e.g., illiterate, women-headed households, elderly)	• Which group of low income is most underserved? • Which group of low income has highest burden of health expenditures/health problems? • What portion of the target "poor" are currently being subsidized? • What size group can be subsidized with available resources?	• National and regional data on health care utilization by income level • National and regional data on household income and health expenditures • National data on incidence of subsidies • National data on health care utilization by demographic characteristics
Services To which services should the poor have "guaranteed" access?	• Essential package of primary health care • Priority services • Preventive services • Hospital care	• Which health care services are most cost-effective? • Which health services are most needed to address main health problems of poor? • Which (needed) health services present highest financial barriers for poor?	• Burden of disease data • Service costs • Epidemiologic profile of the poor • Pattern for the poor of health service utilization and spending for major types of health services
Financing What should the financing source be for covered and non-covered services for the poor?	• Direct tax (income) • Indirect taxes (e.g., value added tax, "sin" tax) • Social security/social insurance • Out-of-pocket (e.g., fees for services, insurance copayments and/or deductibles) • Combination of above	• What is current financing mix for health services? • What are potential amounts available from each source for funding the poor? • Which sources of financing are most compatible with administrative capacities?	• National health accounts • Household survey data on current health expenditures by poor, and percent of income represented • Current coverage by each source of funding for poor and other income groups
Providers Who should provide covered and uncovered services for the poor?	• Public provider: Ministry of health, centralized. • Public provider: local government, health authority • Social security/social Insurance provider • Private for-profit or NGO provider • Combination of above	• What is current public-private provider mix in the country? • What is relative quality of service providers? • What is potential capacity of public and private providers to serve the poor? • What is the implication of dual public-private practice by physicians and/or other health workers? • Are private providers willing to serve the poor?	• National health accounts • Public and private provider survey/inventory • Current utilization patterns in public and private sectors by poor and non-poor • Geographic distribution of providers and the poor population
Central and local government role What is the role of central and decentralized level in funding and providing covered services for the poor?	• Full central-level funding and ministry of health provision • Full central funding and full local public provision • Full central funding and nonministry of health provision (e.g., contracting with private providers) • Combination of local and central funding and provision • Inter-institution coordination (ministry of health, social insurance)	• What are the current roles and structure of decentralization? • What is the current resource mechanisms from central to local health level? • What is the management and financing capacity of local-level health authority? • What are the set of payment and incentives required to serve the poor under decentralization?	• National health accounts • Central and local tax laws and capacity. • History of central and local funding for health care services • Management evaluations at local level • Financial and payment structure analysis • Stakeholder interviews

Table 4b: **Implementation Decisions and Options to Improve Equity in Health Service Delivery and Financing for the Poor**

Equity Decision	Policy & Program Options	Issues	Information & Analysis Needed
Target group eligibility criteria Who are the poor? How to measure their ability to pay (means testing criteria)?	• Income; income and assets • Ownership of property, assets and/or goods (e.g., land, type of house, TV, etc.) • Eligibility for other public subsidies • Informal judgments (e.g., personal appearance, community knowledge) • Employment status • Female head of household • People who "self-target" by choosing available "free" services or goods	• How accurate are different means testing methods likely to be? • What are the administrative complexities and capacities required of each method? • What are the training and record keeping requirements of each method?	• Evaluation of current methods, using household or patient exit surveys, and health facility records regarding health service fee and fee waiver experience of poor and non-poor • Evaluation of other program experience with subsidies for the poor (e.g., food supplementation) • Evaluation of other country experiences
Eligibility process Who should determine elegibility?	• Central-level criteria and records (e.g., from income tax records, other social service eligibility) • Local government level, using local or central criteria and records (e.g., land ownership, local tax payment, employment status). • Health facility level using centrally or locally promulgated criteria • Health facility level using health worker or community discretion • Self selection (i.e., free of charge public hospital attendance)	• How accurate and accessible are different sources likely to be? • What are the administative complexities and capacities required of each method? • What are the training and record keeping requirements of each method?	• Evaluation of current practice, using household or patient exit surveys and health facility records, regarding health service fees and fee waivers for the poor and non-poor • Evaluation of other program experience with subsidies for the poor (e.g., food supplementation) • Evaluation of other country experiences
Provider incentives What funding and institutional arrangements should should be used?	• Direct subsidy to the poor (e.g., vouchers, sliding fee scale, waiver, exemptions) • Direct subsidy to providers through: - fixed global or earmarked budget to decentralized ministry of health units or local government units - performance-based contract with public, social insurance, private providers, based on competitive bidding or sole source -grant to provider (e.g., bed grant, basic operating grant, assign public sector worker to social insurance or private facilities) -informal agreement with provider -combination of payment methods (e.g., budgets, capitation, case-based DRGs, fee for service)	• What is most cost-effective way to target the subsidy, given current country situation? • Which payment mechanisms provide the greatest incentive for providers to serve the poor? • Which mechanisms incorporate strongest incentives to the poor to use services? • Which arrangements are most administratively compatible with arrangements in place for non-poor patients? • What regulatory capacity and monitoring is needed?	• Cost-effectivenes studies of current experiences or simulations • Evaluation of current provider payment experience • Provider and consumer interviews • Map of public and private providers and population (geographic distribution) • Review and evaluation of current country and other nations' experience • Cost of incentives/subsidies • Administrative cost/feasibilitiy of options
Target group incentives What non-financial incentives are needed to encourage utilization of covered services by the poor?	• Better geographic access • Lower travel and waiting time • Provision of outreach services • Incentives to seek care (e.g., coord. with schooling, food supply) • Information, education and dissemination • More accommodating facility hours, worker attitudes, and motivation	• In addition to financial barriers, what are other most important barriers to use of health services by the poor?	• Map of health facilities and target population (geog. distribution.) • Household or patient exit surveys • Provider and expert informant interviews

making this choice relate to the availability and sustainability of funds from each source, along with how equitable the combination of financing methods is. While the choice of funding sources and making cost projections under alternative scenarios can be complex, many funding options exist and new combinations can be devised that suit a country's particular circumstances and reform goals.

As in broader health reform efforts to increase efficiency, it is important to build in incentives for efficiency and provision of cost-effective care in implementing equity policies for the poor and other target groups. In general, incentives for efficiency increase when the payment method includes some financial risk for the provider, is linked to provider performance, and allows the provider flexibility in using resources.

Central and local government roles

In the context of decentralization being implemented in many countries, deciding the respective service delivery and funding roles of central and local governments is key to developing an equity policy. A good deal of debate focuses on the impacts of decentralization policies on the poor and on the availability and quality of health services previously provided and funded by the central ministry of health. Decentralization increases equity when it encourages decentralized authorities to make more effective use of resources targeted to communities' specific needs. Decentralization may lead also to mismanagement, more inequitable distribution of health care resources, and loss of coverage.

Currently there are many variations in the scope and content of decentralization. Evidence about results is mixed, and generalizations about impacts on equity, or on the poor specifically, are difficult. Nevertheless, experience suggests that to avoid negative impacts on equity, access, quality, and sustainability, it is important that central and local authorities are clear and in agreement about their respective responsibilities to ensure adequate funding, service delivery capacity, quality, performance monitoring, and feedback to refine policy and practice as needed.

Providers and incentives

Experience shows that equity policies need to make explicit decisions about the range of health care providers expected to deliver services to the poor or other target group. In general, countries assume that the poor will use public, i.e., ministry of health, facilities and that these facilities will be their primary, if not exclusive, source of care. In recent years, however, much evidence demonstrates that the poor as well as better-off population groups are spending large amounts of money – often more than half the spending in the country's health sector – on health care services and medicines in the private sector. Indeed, countries with lower per capita income tend to have the highest shares of private spending for health.

Ministries need to consider incentives, capacity-building issues, current utilization patterns of the poor, and cost-effective approaches in making explicit decisions about which providers they expect to serve the poor under a reformed equity policy. For public sector health providers, the ministry of health may need to explore incentives such as new career status, working condition, and monetary incentives to motivate health workers to improve performance to better serve the poor and other consumers. While public providers and nonprofit NGO providers are accustomed to providing health care to the poor, special steps may be needed to ensure they have the service delivery and administrative capacity to manage an improved equity policy. Incentives and/or capacity-building measures may also be needed for providers at the municipality or other decentralized level.

For private for-profit providers, special incentives may be needed as encouragement to serve the poor or to locate in underserved areas. All private and social security providers will need to have reliable funding through direct subsidies or reimbursement mechanisms to guarantee they will at least recover costs of providing an agreed on standard of quality service and medicines for the poor. Payment formulas can also be adjusted to ensure that providers do not discriminate against patients with complex illnesses and costly treatment needs.

Target group incentives

Removing financial barriers to use of health care is the most commonly proposed strategy for providing incentives to the poor to increase their utilization of needed preventive and curative health care. Usually the strategy focuses on providing fee waivers or exemptions. Under this option, the provider may cover the costs of caring for the poor with a fund of pooled resources from other facility service fees. The provider may also receive payment from the community; from contracts or grants from the government based on capitation, diagnostic case, or other reimbursement method, or from a special ministry of health budgetary line item for public sector providers. Some countries have established solidarity mechanisms among facilities or geographic areas that allow cross-subsidization between richer and poorer areas where more fee exemptions are needed.

Other options for removing financial barriers include government-funded vouchers that consumers can use to pay any provider of their choice. More expanded options would include removing the barriers posed by costs of transportation,

provision for accompanying family members, or lost income from travel and waiting time. Each of these options, or combinations, provides different incentives and has different implications for ease of understanding by the poor and for feasibility of implementation by the provider.

In addition, many studies have shown that financial constraints are only one of the reasons for utilization differences between the poor and non-poor. The poor usually face greater non-financial barriers as well. Non-financial barriers include those related to geographic access, different perceptions of the usefulness of various health services, and/or cultural differences in self-recognition of illness. In other words, implementation of fee waivers or exemptions alone cannot do the whole job of expanding access or increasing utilization for the poor. It is equally necessary to reduce non-financial barriers through actions to extend outreach; lower travel and waiting time; provide information, education, and communication services; change health worker attitudes; and improve quality and other incentives.

Indicators for Monitoring and Evaluating Equity Strategies

It is important to build a monitoring system into the design of an equity strategy and to identify evaluation indicators simultaneously with determining the policy objectives and implementation details of the strategy. No single set of equity indicators exists; each country needs to tailor indicators to its specific equity programs and objectives, as well as to its broader reform goals. Box 6 summarizes how Chile approached an evaluation of equity using indicators specific to the structure and objectives of that country's health financing and service delivery system.

In general, countries will find it useful to identify indicators for management purposes to permit mid-course implementation corrections – that is, indicators that track key benchmarks and processes that are essential to reaching the equity objectives over time. Several agencies (e.g., the Pan American Health Organization, the World Health Organization, and the USAID Partnerships for Health Reform project) have identified general health reform indicators that could be adapted to monitor equity impacts and their links with broader health reform. (See bibliography.)

It is also useful to identify indicators of interest to key stakeholders such as ministers of finance and ministers of health – for example, measures of efficiency, financial sustainability, and effectiveness of the equity strategy. Some countries may also develop indicators of interest to more general audiences, such as members of parliament, the media, and the public; this "public relations" information can help maintain consensus and support for the reform program and marshal additional support as needed.

For these process- and results-oriented measures, it is most effective to have baseline data that show the situation prior to introduction of the new equity policy, and periodic measures during implementation of reform. "Snapshots," or one-time measurements, can be misleading because they do

Box 6. **Measures of Equity in Chile**

In response to a doubling of public health spending in the early 1990s, the Ministry of Health and the National Health Fund (FONASA) in Chile sought, in 1996, to evaluate the equity and efficiency of health financing and service delivery. They developed several explicit criteria that matched the operation and objectives of their mixed health system.

Chile has a mixed health financing system that includes a public insurance program, FONASA, and several private health insurance firms, called ISAPREs, that have been created since 1981. By 1994, FONASA covered about 62 percent of Chile's population. Approximately 41 percent of FONASA beneficiaries are indigent and the others make payroll contributions to the Fund. ISAPREs cover about 26 percent of the population, mainly middle- to upper-income individuals. Workers can choose whether to have their payroll tax for health applied to coverage under FONASA or under an ISAPRE, which have higher premia. In addition to payroll tax funding, FONASA is financed through a government subsidy from general tax revenues and co-payments from users of the public health system and by FONASA beneficiaries.

FONASA classifies the population into five income groups and is designed to provide a full subsidy to members of the lowest income group, who are exempt from payroll contributions and from co-payments at public facilities.

The 1996 evaluation examined how well government funds were targeted to the poor and how well FONASA financing was aligned with ability to pay (i.e., how progressive it was). Key findings indicated that

- Government health subsidies were well targeted, with about 90 percent reaching the indigent and 8 percent going to other low-income beneficiaries.
- About 2.5 percent of government subsidies leaked to higher income, non-beneficiaries of FONASA.
- The indigent received the highest amount of annual net benefits per capita, followed by low-income beneficiaries, and the government paid for all the health services that the indigent received.
- Non-indigent FONASA members covered 94 percent of the costs of services they received through their payroll contributions and co-payments. Higher income beneficiaries provided significant cross-subsidies to low-income ones, making the internal financing of FONASA somewhat progressive.
- Evasion of FONASA's payroll tax was pervasive, although public providers delivered care on an equal basis regardless of the patients' contributions to FONASA.

Source. Bitran, R. et al. 2000. "Equity in the financing of social security for health in Chile." *Health Policy* 50: 171-196.

not reflect whether equity is improving, or whether inequities are increasing.

Table 5 provides illustrative indicators for monitoring and evaluating equity strategies targeted to the poor. The list is not exhaustive, many indicators require careful interpretation, and no international norm exists for any of the numerical values, rates, or percentages. Individual countries would not use all indicators simultaneously, but would select a limited set of indicators – or develop a limited number of other measures – that are most relevant to the specific equity and health sector reform objectives in the given country setting.

Experience with Developing Operational Equity Strategies

Some common themes have emerged from country experiences that are especially applicable in the context of current health reform efforts. These themes are also key for developing equity strategies that can move beyond policy statements to effective implementation and, ultimately, improve health status for the poor or other target groups.

- ***Establish political consensus***
  To help ensure an effective and politically sustainable equity strategy, it is important that the strategy be based on evidence, clear goals, and consensus-building.

- ***Identify magnitude of the equity problem***
  The first step in designing an equity policy is to identify, quantify, and reach consensus on "the equity problem" in a country: Who exactly is the "disadvantaged" target group? Which important health services do they lack or not use? What are the main causes of the inequity related to access, utilization, and/or financing of health services? The next step is for relevant stakeholders to reach consensus on the specific objectives of an equity policy that addresses the problem.

- ***Match objectives with evidence***
  Depending on evidence about the magnitude and scope of the equity problem identified, a range of solutions is possible, e.g., find more appropriate, higher quality, or more cost-effective providers for the target group; increase the target group's utilization of specific health services; make access more equal to access of other groups; remove financial barriers and reduce the out-of-pocket spending for health care that the target group is required to pay.

- ***Spell out eligibility criteria***
  Implementation issues related to eligibility are usually as difficult to resolve as design of the overall equity strategy. For example, implementation decisions about specific criteria for identifying the poor or who should do this identification have technical elements related to availability and reliability of records, administrative capacity, and likely accuracy or error rates. They also have cultural and political implications, provide more or less scope for subjective judgement in the eligibility determination, and require incentives to motivate providers to implement them effectively.

- ***Estimate the costs and cost-effectiveness of the proposed strategy***
  An essential part of developing an equity policy is to cost the various options under consideration, identify the source(s) of funding for those costs, and adopt the most cost-effective approaches to providing or funding services. Choosing a cost-effective method with built-in performance and quality incentives for implementing the equity policy is important to ensure that public resources needed to fund the program are well used. This will avoid unexpected and unaffordable costs during implementation and ensure long-term financial sustainability. More immediately, it will help to secure the support of the ministry of finance.

- ***Identify funding sources and methods***
  Many policies to ensure equity for the poor or other target groups have failed to achieve impact because policymakers have failed to consider how the measures will be funded and what combination of sources and methods will be used. Countries with complex funding methods already in place can integrate funding of services to the target group. And countries with severe ministry of health budget constraints need to decide which services they will fund for which population groups with their scarce funds in order to meet equity, efficiency, and financial sustainability goals simultaneously.

- ***Coordinate equity objectives with other health reform goals and incentives***
  To be effective, the overall design of the equity strategy must take account of the existing health financing, organization, and delivery structure of the country and be integrated with other reform efforts the country may be undertaking. This point is also critical to ensuring that equity policies contribute to other reform goals and not compete with them. Careful design work can ensure that equity goals are met simultaneously with efficiency, quality, and financial sustainability goals.

Table 5: **Illustrative Indicators for Tracking Progress to Improve Equity for the Poor in the Health Sector**

Equity Outcome	Indicator (for the poor compared with other income groups)	Data Sources
Improved health status	• Nutrition status indices • Fertility rates • Maternal mortality rates and ratios • Infant and child mortality rates • Life expectancy • Reported health status; days missed from work due to illness; other	Household surveys
Improved access	• Percent of poor with access to safe drinking water • Percent of poor with access to adequate sanitation facilities • Percent of poor women with access to quality emergency obstetric care • Percent of poor women with access to modern methods of family planning	Household surveys
	• Percent of rural/urban poor residing within x kilometers of a hospital providing 24-hour emergency (obstetric) care • Percent of rural/urban poor residing within x kilometers of a health facility providing a package of basic health services • Percent of rural/urban poor residing within x kilometers of a health facility staffed by a doctor	Census data, health facility maps
	• Regular availability of basic medicines in public health facilities serving a high portion of poor clients	Facility surveys
Improved utilization	• Percent of poor seeking care/using health services when sick • Percent change in number of total and per capita primary health care visits by poor • Immunization coverage rates for the poor • Percent of births by poor women attended by trained health worker	Household surveys
Improved financing	• Monthly household out-of-pocket spending for health as percent of total monthly household spending	Household surveys
	• Percent of poor with health insurance coverage • Average amount paid by poor person for outpatient visit (and related transport) to public/private health facility compared with monthly per capita income in poor household • Average amount paid by poor individual for medicines (and related transport) for typical outpatient illness episode as percent of monthly per capita income in poor household • Average amount paid by poor individual for typical hospital stay (and related food, transport) as percent of annual per capita income in poor household • Percent fee exemptions granted to poor who use public health facilities • Percent of poor who use public heath facilities and who receive fee exemptions • Percent fee exemptions going to poor in relation to poor's proportion in the population	Facility surveys, household surveys
	• Ratio of share of government (central and/or local level) health subsidies received to share of total income received by the poor (e.g., by the poorest 20 percent of the population) • Ratio of Gini coefficient for public health care subsidies to Gini coefficient for total income	Household surveys, gov't health expenditures by provider type, facility service data

For example, if the design ignores newly decentralized municipalities and districts, the target group may not be served as planned. The strategy also will fail to serve target groups unless incentives ensure that both public and private providers are willing and able to undertake their part in the equity program. Design of the equity strategy can incorporate the target population into new organizational, contracting, funding, and incentive structures underway for the population at large.

▲ ***Monitor, evaluate, and make mid-course corrections***

Few countries can get the equity policy "right" the first time – and health sector conditions continually change in ways that shift provider and consumer situations and behavior. To keep pace with unpredictable impacts and changing conditions it is important to have monitoring and evaluation systems in place that can measure progress toward specific equity objectives. It is also useful to keep pace with international experience for lessons that can be learned from other countries. The evidence-based policy development process undertaken in initial stages should be in place to consider feedback information and consensus-building should be used to make mid-course corrections.

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